2006 Mental Health Residential Treatment Cost Report

Questions and Answers

Schedule A, Part I:

1) Q. What do I enter on line item 7 if I have multiple facilities?
   A. Enter "See Schedule A-1" and complete Schedule A-1 with all Medicaid Provider #s.

Schedule A, Part III:

2) Q. How should I complete the Resident Days section of Schedule A?
   A. There are three separate distinctions for Resident Days reported on Schedule A:
      1. Census Days (line items 14 and 16)
      2. Licensed Bed Days Available (lines 15 and 17)
      3. Available Bed Days (lines 15a and 17a)

   The 3 distinctions are further broken out between treatment and non-treatment. This section of Schedule A, as with the entire cost report, is designed to be all-inclusive. It covers Mental Health Residential Treatment Days as well as days for all other services, which are unique for each provider. For example, ICF-MR Days would be included on line 16 in the "Other" box. Days entered on line 16 should reflect actual census days. Please refer to pages 6 - 8 of the updated Line Item Instructions for additional information to complete Schedule A, Part III – Resident Days.

3) Q. Where should I include Therapeutic Leave Days (TLD)?
   A. Therapeutic Leave Days are included on line 14, which is the *Total Number of Non-Medicaid (i.e. non-treatment) Resident Census Days* and should be included on line 15a, *Available Bed Days for Non-Treatment (i.e. non-Medicaid) Resident Care*. The only portion of TLDs that are covered are Room and Board (R&B) expenses. The days are not included as Treatment Days, but are included as Room and Board days on columns 8 - 9 of Schedule C. For additional information on Therapeutic Leave, please go to page 2 of the following link: http://www.dhhs.state.nc.us/dma/plan/y.pdf

Schedule A, Part IV:

4) Q. What should I do on the signature section if I do not have Audited Financial Statements?
   A. Make sure the Chief Executive/Agency Official's and Preparer's Signatures are included. The Auditor's Signature would not be included unless Audited Financial Statements are submitted. Providers are required to include the financial statements which support the submitted 2006 Mental Health Residential Treatment Cost Report. Audited financial statements are a requirement only if an agency already regularly has them prepared.

Schedule B:

5) Q. What are Title IV-B Funds listed as Other Federal Funds on Schedule B?
A. These funds pertain to placement of children in suitable adoptive homes.

6) Q. Where should I include revenue from the LME?
A. All LME revenue should be included on line 10.

7) Q. Where do I record Donations?
A. Cash donations should be included on line 9.

8) Q. Where are Department of Social Services (DSS) funds entered?
A. DSS funds are entered on line 7 – County Funds.

9) Q. Where do I get Total Expenses to put on line 12?
A. This amount comes directly from the Income Statement corresponding to this cost report period. This value also flows to Schedule C, just below line 106 in the Total Column.

Schedules C and C-1:

10) Q. What are the differences between the Schedules C and C-1?

A. These two schedules have identical line items. Schedule C-1 is specifically for Treatment Expenses and feeds to the Treatment section of Schedule C. Schedule C includes all expenses and must tie to the financial statements. Treatment Expenses for Levels of Care are separated into columns 1 - 4. For all Treatment Expenses in columns 1 – 4, there should also be Room and Board (R&B) expenses in the corresponding Levels of Care (columns 7 – 10). R&B includes Supervision and is also referred to as Program Expenses. Columns 5 and 6 of the Treatment Expense section are for PRTF and Other, CAP-MR and ICF-MR expenses. The remaining expense columns are Other Programs, Fund-Raising and Administrative costs. Each line item is also grouped by the following row sections:

1. Medicaid Treatment Expenses
2. Program Expenses
3. Social Services
4. Housekeeping/Shelter Costs
5. Dietary/Food Costs
6. Personal Need Costs/Clothing
7. Recreation Costs
8. Education Costs
9. Transportation
10. Other Costs
11. Depreciation
12. Non-Allowable Expenses

Cells are open on these schedules depending upon which line item expenses are applicable for which column.

11) Q. Why are Non-Allowable Expenses/Exclusions included on the cost report?

A. The 2006 Mental Health Residential Treatment Cost Report is all-inclusive in that it allows providers to record all operating revenue and expenses. This allows for reconciliation between the cost report and the corresponding financial statements. However, only Medicaid-allowable costs and days are used to calculate rates for these Residential Treatment services.

12) Q. The LME requires that we carry vehicle insurance for client transportation, which is very costly. Why is this expense not Medicaid-eligible?

A. Upon further review following the training classes, DMA Rate Setting has determined that vehicle insurance that is specific to the transportation of residents for Treatment can be entered on line 9 (Other) of Schedule C-1 if the salary for the person providing the transportation is also included on Schedule C-1 lines 1a, 1b or 1c. The portion of the expense that is used to by groceries, visit school, parents, etc. should not be included on Schedule C-1, line 9, but may be included on Schedule C, line 61 for the specific Program portions. The Administrative portion may be entered on line 101. However, this Administrative portion is excluded from Mental Health Residential Treatment rate setting costs.

13) Q. What are the differences between the salaries listed on line items 1a, 1b and 1c compared to those entered on line 12?

A. The Salaries/Wages entered on 1a, b and c are for Treatment personnel and are Clinical in nature. 1a is for Direct Care staff, such as Associate and Para – Professionals; 1b is Qualified Mental Health Professionals; and 1c is Other Staff (i.e. Licensed Professionals, Clinical Directors and Trainers, etc.). Treatment Costs are covered by Medicaid as long as there is medical necessity as per the resident's Individualized Service Plan. Service definitions for Residential Treatment (RT) Levels I, II, III, IV and PRTF, which include specific details of the treatment costs to be included, are located at http://www.dhhs.state.nc.us/dma/bh/8A.pdf . The RT Levels of Care are on pages 81 – 99 and PRTFs are on 104 – 107 of this link.

Line item 12 also includes salaries for Direct Child Care staff. However, this line item is for Salaries and Wages related to Daily Supervision and other functions which keep the Program operational on a day to day basis. If clinical professionals performing Treatment Services (as detailed in the paragraph above) also perform Supervisory duties, the hours (FTEs), salaries and related benefits and taxes need to be **prorated** between Treatment Expenses (lines 1a, b and c, 2 and 3) *and* Program Expenses (lines 12, 13 and 14). Examples of activities included on line 12 are supervised recreational activities, house parent duties, maintenance, food preparation and other "non-clinical" activities.

14) Q. Where do I enter salaries for Administrative Staff?

A. Administrative Staff salaries may be entered on line item 88 for the specific Program Expenses, columns 5 – 12, or on line 88 in the Administrative Expense columns 13 – 14 (corporate overhead).

15) Q. Why are Administrative costs broken out on the Cost Report?

A. Federal guidelines dictate separation of Administrative expenses from Program expenses as well as breaking out of all Fund-Raising and Advertising in support of Fund-Raising.

Schedule D:

16) Q. Why is Schedule D needed?

A. Schedule D is required in order for providers to declare Related Party Transactions. It recognizes that some facility staff wear multiple hats, but have salaries indicative of only one function/role. This schedule allows for more parity between large companies who may have more extensive payrolls as opposed to smaller companies.

General Information and Instructions:

17) Q. Since my fiscal year-end is December 31, 2005, I will not have financial statements in time to complete the cost report by the deadline. What data should I use to complete the cost report?

A. You are requested to use the financial statements for the most current completed fiscal year end that will allow you to meet the January 31, 2006 deadline. In this case you may choose to report 2004 data.

17) Q. Will there be an extension to the January 31, 2006 deadline for submitting the cost report?

A. There will be no extensions to the cost report deadline.

18) Q. Will an inflationary factor be applied to 2004 costs reported?

A. Upon review of the cost data, DMA Rate Setting will make a determination as to any necessary adjustments.

19) Q. Why are audited financial statements not required?

A. Not all providers have audited financial statements and the State does not want to inflict additional financial burden on the providers. For this reason, unaudited financial statements are also acceptable. In addition, this year the Division of Medical Assistance Audit Section will support the rate setting process by conducting field audits of randomly selected providers.

For additional information, please refer to the updated Line Item Instructions which are also posted on this website. You may also call Deidra Oates in DMA Rate Setting at (919) 855-4202.